

# **EXHIBIT V - Part 2**

## **Bondi Deposition**

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1     **whatnot?**

2           A.     Well I don't accept -- I don't accept that  
3     statement you just made, but I'll answer the question.  
4     That's -- there's no -- would have been no easy way to  
5     do that other than asking the people who are there. In  
6     this case, the medical students are ever present in the  
7     hospital. If you actually want to know stuff, they --  
8     they're everywhere, and they also are unobtrusive  
9     because they -- because since they don't have like a  
10    direct responsibility, you know, as like the residents  
11    do, they are -- they are keen observers.

12                So this was a compelling amount of information  
13    that then Mr. Crews, I assume now Dr. Crews provided.  
14    Medical students see that kind of stuff. They stick  
15    onto -- they stick onto to residents because they want  
16    to make sure they don't miss anything, and they also are  
17    very eager to please.

18                Every one of as a resident, as an antidote  
19    about a medical student following us into the bathroom  
20    because they're so -- they stick to us so much. So  
21    that's why I disagree with your statement about him not  
22    seeing things. I mean if he was on a rotation at the  
23    same time as Dr. Papin, I do believe that he would have  
24    a sense of when Dr. Papin arrived and when Dr. Papin saw  
25    those patients.

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1           The other thing I would add about a medical  
2   student complaint, is for the medical student to  
3   complain about a resident's professionalism, that is  
4   extraordinarily unusual. Medical students like to lay  
5   low, when they complain, they tend to complain about  
6   things like, you know, not getting, you know -- you  
7   know, having to work long hours, but they do it in  
8   private. They almost never make formal complaints  
9   because their grades are so important to them.

10           **Q.    But you don't know one way or the other**  
11 **whether Dr. Crews was asked if he had any complaints**  
12 **about a doctor or on his own --**

13           A.    No. No.

14           **Q.    -- volition and freely --**

15           A.    You were just asking me about --

16           **Q.    -- submitted a complaint?**

17           A.    You were just -- you had made the statement  
18 that he would not be in the position to observe, and I  
19 disagree with that. I think he would actually be the  
20 ideal person to observe.

21           **Q.    But you don't know for sure one way or the**  
22 **other, you weren't there; right?**

23           A.    I wasn't there, but I was asked to hear what  
24 he said in the hearing, and I found that his testimony  
25 was compelling. I didn't see a reason why he would had



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1 a reason to lie or to fabricate the testimony. And  
2 furthermore, he had no reason to bring it up in the  
3 first place unless he was really worried about what was  
4 going on.

5 Q. Are you aware of whether Dr. Crews has since  
6 ever recanted any of his testimony, and if he did  
7 regarding these incidents, would that have changed your  
8 -- would that change your opinion materially regarding  
9 the fact of whether Dr. Papin, his professionalism and  
10 candor issues were as bad as everyone thought they were?

11 A. You asked a bunch of questions. But the first  
12 one is, I have no idea whether he recanted any of this.  
13 My last contact with Dr. Crews was on the day of the  
14 hearing. And once again, I assume he's Dr. Crews now.  
15 He was Mr. Crews then. In terms of whether it would  
16 have made a difference, I believe I kind of answered  
17 that question at the beginning of the deposition where I  
18 said that, you know, there's a bunch of information  
19 here. The information that we reviewed, there's a lot  
20 of it. Any one thing was not a linchpin in terms of our  
21 decision to support Dr. Papin's termination.

22 I think -- and if the committee were to, you  
23 know, we'd have to basically look at what would have  
24 changed. You know, one thing wouldn't have made a  
25 difference.



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1           Q.    There were issues as well that Dr. Crews  
2   reported regarding Dr. Papin making another female med  
3   student or resident feel uncomfortable, you know in a  
4   male to female interaction perspective. Do you know why  
5   none of that was brought up here in this Notice Letter,  
6   but yet it was brought up at the hearing, at Dr. Papin's  
7   Appeal Hearing?

8           A.    I can't speculate onto either of those  
9   questions. But my comment to you or to the deposition  
10   is, that because that was such an indirect accusation,  
11   and there were no facts surrounding it, and the person  
12   who was uncomfortable wasn't testifying before the  
13   committee, that did not -- that was something that --  
14   that we kind of pushed off to the side. It didn't seem  
15   that we could use that to base our decision on.

16          Q.    So the patient that would have been admitted  
17   to the ICU, how would that patient have actually arrived  
18   there if Dr. Papin had not sent the orders for that  
19   person to go?

20          A.    The orders don't necessarily follow the  
21   patient flow.

22          Q.    But the patient did make it to the ICU, so Dr.  
23   Papin presumably did send the orders. I guess --

24          A.    No. The order -- the orders don't necessarily  
25   determine that the -- how the patient arrives into the

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1 ICU. So I don't know the details of where this patient  
2 came from. I would assume they came from the emergency  
3 department. The emergency department would have  
4 emergency department orders. I can't remember at UMMC  
5 whether the emergency department physicians put in the  
6 order to admit them to the trauma service or the CVICU  
7 service or general surgery or whatever service they end  
8 up on. But the orders are often -- certainly, in my ICU  
9 in Jackson while I worked there, in the pediatric ICU,  
10 which is a different environment, as well as my current  
11 ICU, the orders are put in as the patient arrives or  
12 when the patient arrives or right before they arrive.  
13 So the orders don't necessarily determine the fact that  
14 the patient is moving in the hospital.

15 MR. SCHMITZ: Tommy, I've got like five  
16 minutes left, then I've got to break for this hearing  
17 that I got coming up in 15 minutes.

18 MR. WHITFIELD: How close are you to  
19 finishing?

20 MR. SCHMITZ: Can we go off the record  
21 for a second.

22 (Whereupon, the deposition was recessed for lunch,  
23 after which the following occurred:)

24 February 3rd, 2021 3:30 p.m.

25 AFTERNOON SESSION



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1 DR. STEVEN BONDI

2 having been previously duly sworn, was examined and  
3 testified further as follows:

4 EXAMINATION BY MR. SCHMITZ (Cont'd):

5 Q. Okay. I'm going to resend the document  
6 because I'm assuming you're not looking at it.

7 A. I am not.

8 Q. All right. It's posted in the chat.

9 A. I have it pulled up.

10 Q. Okay. So if you want to look at page three of  
11 four of the PDF, it starts on January 10th, 2017.

12 A. Yes.

13 Q. Okay. On January 10th, 2017, that's the same  
14 day that -- are you aware that that was the same day  
15 that Dr. Earl was having his meeting agreeing to a  
16 remediation plan with Dr. Papin?

17 A. I know that -- I know that now, you know. I  
18 know that those -- that that was -- that that was the  
19 date of that plan I believe.

20 Q. Sure. And there's a list of ten things below  
21 here that Dr. Mahoney e-mailed Dr. Earl and Ms. Greene.  
22 Do you know whether Ms. Greene or Dr. Earl had solicited  
23 these complaints on Dr. Mahoney, or that she sent this  
24 on her own volition?

25 A. I have no idea.



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1           Q.    Are you aware of whether any of the complaints  
2   either by William Crews, Colin Muncie or -- were  
3   submitted sort of at random or at the -- were these  
4   complaints all submitted at the request of Dr. Earl and  
5   Ms. Greene?

6           A.    I have no idea how they came to the attention  
7   of Dr. Earl or Ms. Greene.

8           Q.    Number nine, we discussed this earlier. It  
9   was reported that Dr. Papin was lying to the Chief  
10   resident about seeing patients before rounds. Was there  
11   any evidence other than I think the antidotal evidence  
12   of William Crews other -- that you're aware of that was  
13   considered about the fact that he was lying about seeing  
14   patients before rounds?

15          A.    Well first of all, I don't know if I would  
16   refer to that as antidotal evidence. But without the  
17   qualifier, I believe in the -- I believe there may have  
18   been a mention of it in the transcript of the HR  
19   conversation, but I'm not positive, that some  
20   information from one of the other residents, but I'm not  
21   positive. But the large substance came from the medical  
22   student Mr. Crews.

23          Q.    Now you have a degree -- one of your majors is  
24   computer science?

25          A.    Yes.

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1 Q. And so an at the hospital, they use extensive  
2 computer documenting, recording systems, everything  
3 that's done in terms of patient care, they're doctor's  
4 interactions with patients is simply documented at some  
5 point within UMMC's computer system; correct?

6 A. No, that's not correct.

7 Q. Okay. So if a doctor is going around and  
8 doing -- or a resident is going around doing pre-rounds  
9 in meeting patients going room to room taking, you know,  
10 vitals or taking notes, that would all be documented  
11 within UMMC's computer system; correct?

12 A. No, that's not correct.

13 Q. How are those things documented?

14 A. Pre-rounding is something that residents --  
15 first of all, residents don't generally take vital  
16 signs. And you don't want the patient care techs in the  
17 children's hospital, it's either techs or nurses.

18 Second of all, pre-rounding is where residents  
19 gather information. They do that by evaluation of the  
20 medical record. They do it by, hopefully, by examining  
21 the patients. And that information is recorded  
22 typically on a piece of paper. Residents will often  
23 print a list of the patients on their service and then  
24 take their notes on that piece of paper. Later in the  
25 day, then they may or may not use that to type notes, to



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1 type, you know, patient -- the status notes that we use.  
2 But the pre-rounding is typically not memorialized  
3 anywhere electronically.

4 Q. So there would be no documentation showing  
5 anywhere whether a resident did or did not do his  
6 pre-rounds?

7 A. There wouldn't be any notes of it, no.

8 Q. Any other documentation that would be able to  
9 show one way or the other whether somebody was coming to  
10 work at a certain time or --

11 A. I mean they're -- I -- I -- I mean I'm sure  
12 there are cameras in the medical center that can show  
13 whether someone is there or not. But I don't know where  
14 those cameras are. The use of one's badge is recorded.  
15 I don't know what the retention on that is. There are  
16 -- certainly, when one enters into the medical record,  
17 there's an audit trail. How robust that audit trail is,  
18 I don't know, in terms of how long it's kept or -- but  
19 my understanding is that it's fairly robust.

20 Q. Would the residents access be accessing the  
21 patients that are on their service to create that at  
22 least not even if they weren't doing notes, but just the  
23 fact, that, hey, I opened up this patient's chart  
24 electronically at 7:30 a.m. on a Tuesday?

25 A. That -- that -- that is within the capability



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1 of the system. I don't know what the specific  
2 capabilities of UMMC's system is right now, but it's  
3 supposed to have a fairly robust audit trail. Yes.

4 Q. Were you or Dr. Papin provided with any  
5 evidence during the time period where Dr. Papin was  
6 alleged to have not been doing his rounds, any audit  
7 trails or any documentation to support the fact that Dr.  
8 Papin was, in fact, not seeing his patients before  
9 rounds?

10 A. No.

11 Q. The next one, number ten. It says: "Dr.  
12 Papin was dishonest about examining a patient that  
13 developed a sacral decubitus wound" -- that's what we've  
14 been talking about today -- in addition, to the concern  
15 of dishonesty, the other concern had to do with a  
16 detrimental action to patient care. Dr. Papin having  
17 told Dr. Mahoney that, upon his observation, a patient  
18 did not have any skin changes. When the patient was  
19 seen by Wound Care, they reported a severe ulcer that  
20 was so significant, surgery was required. This could  
21 not have happened over the course of a few days and the  
22 resulting action could have lessened had Dr. Papin  
23 examined the patient and reported it."

24 And again, you said you did not review any of  
25 the records for this decubitus ulcer patient; correct?

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1 A. That is correct.

2 Q. And would it have changed your opinion  
3 regarding this event in potential capability of Dr.  
4 Papin, if you had known at the time of the hearing, that  
5 a review of this patient's medical records, which show  
6 that Dr. Mahoney looked at this patient's records, which  
7 included notes and pictures of the decubitus ulcer and  
8 its development in the three, two -- two to three weeks  
9 prior to this?

10 MR. WHITFIELD: Object to the form.

11 Q. (BY MR. SCHMITZ) She reviewed those notes 73  
12 times according to the audit trail?

13 MR. WHITFIELD: I'm going to object to  
14 that as a mischaracterization of that document. It does  
15 not say she looked at the wound care notes.

16 Q. (BY MR. SCHMITZ) Okay. But she looked at the  
17 patient's chart 73 times over the three weeks, would  
18 that change your opinion of whether she was unaware of  
19 this?

20 A. It might. I think it would -- it would depend  
21 upon a broader picture.

22 Q. Okay. Would it change your opinion at all  
23 regarding the capability of Dr. Papin if even up to the  
24 day -- right up until when the wound -- decubitus ulcer  
25 wound was found, that there was a scab covering the



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1 wound that concealed the observation of the depth of the  
2 ulcer prior to when it was brought to Ms. Mahoney's  
3 attention as being something of -- her prior to her  
4 alleging that this was Dr. Papin being untruthful about  
5 examining the patient?

6 A. That would not change. That would certainly  
7 not change my impression, no. Because the scab or the  
8 word you'll see is "eschar." But that's part of the  
9 wound itself, and that requires evaluation.

10 Q. Would a first-year resident typically know  
11 that you have to peel back the scab, or is that sort of  
12 a teaching moment for something like this?

13 A. I can't comment on that because I'm not a  
14 surgeon nor do I supervise surgical residents. I think  
15 that question is better suited to a resident in -- or to  
16 a surgeon.

17 Q. But you do see in Pediatric ICU, would a  
18 first-year resident in the Pediatric ICU under your  
19 supervision, would you expect that person to know that  
20 if someone has a scab on their back, that that scab  
21 should be peeled back to check for decubitus ulcers?

22 A. Wound care is a core competency of general  
23 surgery. So that would be asking me as if a first-year  
24 law student had known that really because it's apples --  
25 it really is apples and oranges. Wound care is not a



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1 core competency of the pediatric resident. First-year  
2 pediatric residents do not rotate in the I -- do not  
3 rotate in the Pediatric ICU, which is where you'd see  
4 the majority of wounds, if any. So I -- I -- it's just  
5 not a fair comparison.

6 Q. Fair enough. And, obviously, there was no  
7 review, to your knowledge, of this patient's medical  
8 records or charts by anyone within risk management that  
9 the nursing coordinators as you put them earlier, they  
10 never viewed any of these records to provide you what  
11 their opinion would be on the care that was provided to  
12 this patient?

13 A. I can't say that, and this is why. It didn't  
14 rise to my level. But it would be extraordinarily  
15 unusual as I stated before, for a -- for a decubitus  
16 ulcer, even a severe one, to get to -- to get to my  
17 level unless there was litigation involved.

18 So even a contemplation of litigation might  
19 not even got up to that level. Because wound -- wounds  
20 are very common. They're typically dealt with at the  
21 unit level by the unit manager, nurse managers, and even  
22 if one of the nurse coordinators in risk management  
23 reviewed those, it's unlikely they would have gotten to  
24 my level. So I do not have any -- I do not know whether  
25 they were reviewed.

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1 Q. Would it change your opinion regarding Dr.  
2 Papin's termination, if up until the discovery of the  
3 decubitus ulcer on this patient, that wound care was  
4 still advising conservative treatment of the scabbed  
5 area for quite some time prior to this?

6 A. I don't think this incident by itself, even if  
7 you completely erased it from the record, would have  
8 changed our determination. This was one of many many  
9 incidents that we assessed and reviewed, and one of them  
10 were even -- several of them in isolation were not what  
11 the decision was based upon.

12 Q. But part of this incident, right, is the  
13 allegation that he was not being truthful regarding the  
14 examination of this patient; correct, that that was  
15 really -- it wasn't that the wound happened or not;  
16 right, I think the main concern for you was that he --  
17 there was allegations that he had lied about whether he  
18 examined this person and that had resulted a patient  
19 harm; would that be fair?

20 A. Yes.

21 Q. Okay. And so if it would show that maybe he  
22 did not lie about that, and then wouldn't that cause the  
23 question many of the other things regarding his  
24 professionalism, which was the overarching theme of why  
25 he was -- why he was terminated?



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1           A.     These incidents were different and distinct.  
2     And so like I said, one incident by itself or even one  
3     -- you know, several of these incidents, would not have  
4     changed the calculus. There were so many different --  
5     there were so many different factors involved.

6           Q.     So previously you testified, that it was kind  
7     of a big deal that whether Dr. Papin had contacted  
8     anyone to admit the patient to ICU, that if he had not  
9     let them know that the patient was coming, that that is  
10    kind of a big deal; right?

11          A.     It's not kind of a big deal, it's a very big  
12    deal.

13          Q.     Okay. So if that's a very -- was any efforts  
14    made to determine who this patient was or to find their  
15    medical records to see what was going on or to look at  
16    call logs or do anything to try to see maybe -- maybe  
17    somebody on the ICU team wasn't being truthful because  
18    they dropped the ball, and it wasn't Dr. Papin?

19          A.     My understanding from the documentation, was  
20    that the other residents and the nurse -- the other  
21    physicians and nurse practitioners that were in the ICU  
22    were asked if they received sign on, on this patient  
23    from Dr. Papin, and that the answer was no across the  
24    board.

25          Q.     But wouldn't those nurses get in trouble,



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1 potentially be disciplined if they were to admit to  
2 something like that?

3 A. Well it's not there weren't -- this isn't  
4 nurses. It's nurse practitioners or physicians.

5 Q. Okay. So either a nurse practitioner or a  
6 physician. If a nurse practitioner, which that's what  
7 Dr. Papin said he spoke to, if it was a nurse  
8 practitioner that had potentially made a mistake,  
9 wouldn't that person be subject to discipline, if they  
10 answered yes to that question?

11 A. I think anybody that was dishonest in dealing  
12 with patient care, there are potential ramifications for  
13 that. Yes.

14 Q. But yet it was -- but you made the conclusion  
15 that only Dr. Papin was dishonest and there was no  
16 potential that there was somebody from the --

17 MR. WHITFIELD: Object to the form.

18 Q. (BY MR. SCHMITZ) -- another side of the story  
19 with respect to the admittance of the patient into the  
20 ICU unit?

21 A. No. Because Dr. Papin explained that he  
22 talked to somebody, he wasn't sure who it was. And then  
23 maybe -- and then later said maybe it was a nurse. So  
24 we heard his side of the story, and it was clear from  
25 what he told us, that he didn't make sure who he talked

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1 to was the right person.

2 Q. But there's two sides to that story; right,  
3 there's two potential outcomes. So either Dr. Papin was  
4 lying or that person on the other end that Dr. Papin  
5 spoke to allegedly; right, was lying?

6 A. That's not what I said.

7 Q. No. No. I'm not saying that's what you said.  
8 I'm saying, there has to be two sides. So there was  
9 either Dr. Papin was lying or the person who took the  
10 phone call that Dr. Papin said he made was lying; right,  
11 if --

12 A. I disagree.

13 Q. -- that even happened. Did anybody --

14 A. I disagree.

15 Q. Did anybody follow-up -- did anybody  
16 investigate that further and write those people up for  
17 not receiving the patient or taking those orders as they  
18 should have?

19 MR. WHITFIELD: Object to the form. If  
20 you can answer that, go for it.

21 THE WITNESS: Well it was a couple of  
22 statements followed by a question. So to answer the  
23 statements. It is true that either the call occurred or  
24 the call didn't occur. But there's also a bona fide  
25 question as to, if the call did occur, who did Dr. Papin



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1 talk to. And Dr. Papin said that he wasn't sure who he  
2 talked to. That in of itself is a problem. When I make  
3 -- when I give sign on, on a critically ill patient, one  
4 of my patients is going to the operating room; for  
5 example, I call the anesthesiologist who is responsible  
6 for that case. I talk to that person by name. I  
7 understand that person's role, and then I sign the  
8 patient up -- out. I just don't call a random person  
9 and sign the patient out not knowing who they are.

10 Q. (BY MR. SCHWARTZ) But do you remember if you  
11 -- 'cause this says on January 3rd, she sent an e-mail  
12 to Renee Greene outlining an incident that had occurred  
13 the prior weekend. So by the time Dr. Papin was given  
14 notice of this incident, potentially maybe by Dr. Earl,  
15 it was three weeks later. Do you remember three weeks  
16 ago if he talked about some patient that -- you know, I  
17 mean at three weeks, once that much time goes by,  
18 wouldn't it be reasonable to assume that he probably  
19 wouldn't remember maybe even seeing that patient at all?

20 A. Well that's a different -- the latter thing is  
21 a different question. But I take sign out and give sign  
22 out the same way every single time I do it. It's  
23 something we focus on. It's actually -- sign outs are  
24 very -- have been identified as a high risk area for  
25 patient care. Every time a patient is handed off,

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1 there's a risk to that in terms the information that's  
2 exchanged not being done effectively and not harming  
3 patient care.

4           So handoffs are huge in patient safety.  
5 That's why we make such a big deal out of them, and  
6 that's part of the substance of what we're talking  
7 about. So, no, I wouldn't just pick up the phone and  
8 say -- and say, "I'm signing this patient out." I would  
9 say, you know, "Is this Dr. Smith, the anesthesiologist  
10 who's going to be caring for baby Jones in an hour."  
11 And they do likewise to me. They would call up and --  
12 and frankly, I know -- at my level, I know some of these  
13 people by name, so. But even when it's people I don't  
14 know, it's an attending from the emergency department.  
15 I'll answer the phone, they'll say, "Is this the PICU  
16 attending." I'll say, "Yes. It's Steve Bondi, I'm the  
17 PICU attending that's on today." And then they'll say,  
18 "I have a patient to sign out to you." And I'll say,  
19 you know, "Let me grab a pencil" or whatever. And then  
20 they sign the patient out to me in a structured way.

21           This is -- this is not a -- this is not a spur  
22 of the moment conversation. These are semistructured  
23 exchanges of information that are critical for patient  
24 for patient. So, yes, I can say for certain that I  
25 signed out three weeks ago or three years ago, that I



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1 knew who I was talking to on the other end of the phone  
2 because we all -- I always do it the same way.

3 **Q. You would be able to figure that out because**  
4 **you take notes about that?**

5 A. Well I take notes when I receive the  
6 information. But I can tell you that I always identify  
7 the person I'm talking to. The only thing is, I'm not  
8 allowed to give patient care information to someone  
9 who's not directly involved in the care of that patient.  
10 Because that's -- that's -- that's -- all of that's  
11 bounded by HIPAA, and we get tons of training on that as  
12 well. We need to make sure that that exchange of  
13 information is to the right person. So that's a  
14 critical aspect of this. You just don't call up and  
15 start -- start signing a patient out.

16 The other thing is, is that if a -- you know,  
17 it wouldn't make sense for a nurse to take sign out from  
18 a doctor anyway. So I, you know, it'd be unlikely for a  
19 nurse just to sit there and get that exchange of  
20 information. I guess that is possible. But the person  
21 making the sign out has an obligation to make sure  
22 they're signing out to the right person.

23 **Q. But a nurse practitioner, that's -- that's**  
24 **acceptable scenario?**

25 A. Well nurse practitioner is a different role

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1     than a nurse.

2           Q.    I understand that.

3           A.    A nurse practitioner is a provider. A nurse  
4     is a -- is a nurse.

5           Q.    Right. The next part, it says: "Ashley  
6     Griffin, RN, registered nurse?

7           A.    Yes.

8           Q.    Sent e-mails on the 9th and 10th citing seven  
9     incidents of inappropriate behavior by Dr. Papin:  
10                Leaving the hospital during a code.  
11                Did not show up on time to pre-round or to get  
12                sign out.

13                So the sign out -- sign in, sign out when the  
14     physicians turn in or relieve one another or residents,  
15     you know, at the end of the shift. There's timestamp  
16     records of that; right?

17          A.    No.

18          Q.    Don't they have to sign in and actually sign  
19     out a piece of paper that I'm Joe Papin, I'm showing up  
20     at 5:00 o'clock?

21          A.    No.

22          Q.    What is the sign in, sign out process then?

23          A.    You're expected to be at the hospital at a  
24     certain time. You know, you formally have a time that  
25     you would be expected to be there. Residents frequently



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1     come in early if the workload dictates that. There are  
2     work rule requirement in terms of accounting for your  
3     hours but, frankly, most of those are done after the  
4     fact, in my experience. I haven't had to account for my  
5     personal hours since I was a fellow, which was almost  
6     ten years ago.

7                 But I don't -- maybe they do something  
8     differently in surgery but -- in terms of formerly  
9     signing in, I don't know. But the sign out is when  
10    you're signing patients out, not when you're signing  
11    yourself out as an employee. It's not like a nine  
12    o'clock maneuver. But when we refer to sign out, my  
13    service has 20 patients, the oncoming doctor and I have  
14    to have some formal communication for us to talk about  
15    those patients, it's another example of the handoffs we  
16    were talking about before.

17                **Q.     Okay.**

18                A.     So, typically, what would happen is, when you  
19    arrive in the morning, you would get there at a certain  
20    time 6:00 o'clock, 5:00, whenever it happens to be, and  
21    the resident who is leaving who was on overnight, would  
22    sit down with you, maybe it might be a team because they  
23    may be signing out patients to different -- they may be  
24    signing out a pool of patients to one, two, three  
25    providers perhaps. And then they give -- they update --

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1 they update the new provider on anything that happened  
2 with that patient overnight that was significant and any  
3 new patients that were admitted to the service. That's  
4 what sign out refers to, and then that process would  
5 happen again in the evening when the rever -- you know,  
6 when the daytime person will sign in to the nighttime  
7 person.

8 Q. Were there complaints from any providers  
9 regarding Dr. Papin not showing up on time for these  
10 sign in sign out meetings to relieve them from their  
11 patient care duties?

12 A. We certainly did not discuss that at the  
13 hearing itself. Whether or not there was anything on  
14 the -- in the resident -- in the resident evaluations, I  
15 don't recall.

16 Q. Number four and five. "Dr. Papin tried to  
17 send a patient home that was not competent despite being  
18 warned." Do you recall any discussion of that or doing  
19 an investigations of that?

20 A. I certainly did not do an investigation of it.  
21 I don't recall that. I don't recall that being brought  
22 up in the hearing.

23 Q. Number five, "Dr. Papin made the female trauma  
24 student incredibly uncomfortable, tried to be alone with  
25 her, and preferentially chose her over the males." Did



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1     **you do any inves -- what was the discussions regarding**  
2     **that, to the best of your knowledge?**

3           A.     I certainly did not do an investigation of it.  
4     And as I mentioned earlier before the break, we felt  
5     that the information provided on that was, there simply  
6     wasn't enough information there to have that be a  
7     consideration of our assessment about whether the  
8     termination was warranted.

9           Q.     Do you know whether that female trauma student  
10    **ever filed any kind of complaints with HR or anything**  
11    **regarding harassment or --**

12          A.     Yeah. I would have no idea. It certainly was  
13    not brought up in the hearing. And HR is of, you know,  
14    that's an entirely different process. And so that would  
15    not have come -- that would not have come to me at risk  
16    management.

17          Q.     Number seven. "Dr. Papin was told to washout  
18    a massive wound on a trauma patient in the ICU. He did  
19    not do it and left." What evidence or basis was  
20    provided to you to substantiate that claim?

21          A.     If I recall correctly, and I'd have to check  
22    the transcript to verify this, that one -- one of the  
23    other residents brought that issue up. That would --  
24    not Dr. Griff -- well it might have been Dr. Griffin.  
25    Not Dr. -- I'd have to look at it. But it was -- I

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1 believe we did discuss that in the hearing.

2 Q. And do you recall Dr. Papin's rebuttal to this  
3 claim that he did not washout this wound on this  
4 patient?

5 A. I believe he said that he did it. Yes.

6 Q. And do you recall Dr. Papin saying that he had  
7 text messages from another resident as well who also  
8 washed -- who also claimed to washout the wound and can  
9 (undiscernible) text messages on the same date and time  
10 he was alleged not to do that, and that the person  
11 claiming he did not wash the wound came after both of  
12 them, so that would have to make it so that both of them  
13 did not wash out the wound when they said they did?

14 A. I would have to refresh my recollection on  
15 that one. I don't remember that particular aspect of  
16 it.

17 Q. Did you ever -- would you have had access to  
18 this patient's records to see if there was any audit  
19 trails or logging into to this patients things to do a  
20 wound washout or a procedure like that on -- if you had  
21 wanted to?

22 A. I had access -- I would have had access to any  
23 of the patients in the medical -- in the medical record  
24 and appropriate access due to my role in risk  
25 management. I did not ever look for that information.



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1 In terms of the audit trail, there's some stuff that you  
2 can see, but a lot of the stuff you have to actually ask  
3 for a specific query on that, and I didn't have the  
4 ability to get that kind of an audit trail, I would have  
5 had to request that to get that, if I wanted it, and I  
6 did not.

7 Q. Other than the -- in the next paragraph, it  
8 talks about Dr. Earl meeting with Dr. Papin numerous  
9 times giving him feedback. Other than the December  
10 20th, 2016, e-mail that Dr. Earl sent to Dr. Papin and  
11 the remediation plan that they both signed on January  
12 10, was there any documentation -- other documentation  
13 of counseling sessions that Dr. Earl had made a record  
14 of to show which issues he had been bringing up to Joe  
15 since the beginning of his residency?

16 A. Yes.

17 Q. What other documents did Dr. Earl provide you  
18 regarding that?

19 A. There was the November -- well Dr. -- I don't  
20 believe Dr. Earl provided them to me. They were part of  
21 the materials at the hearing. And as I mentioned  
22 before, I think actually Mr. Dillard is the one who gave  
23 me the packet. But there was his November summative  
24 evaluation for his first -- first half of his intern  
25 year.

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1 Q. Other than those dates, so November, December,  
2 we've got two documentations of two meetings between Dr.  
3 Earl and Papin, prior to that, there's -- it was just --  
4 there's no -- there's no documented counseling --

5 A. There's no document of the conversation.

6 Q. -- sessions?

7 A. There is the -- there are the monthly -- the  
8 monthly feedback that one would get after each rotation.  
9 But there's no documentation of a conversation between  
10 Dr. Papin and Dr. Earl attached to those. If that's the  
11 question?

12 Q. And you don't recall whether you had any part  
13 in providing this Notice Letter or working to provide  
14 this Notice Letter to --

15 A. Oh, I do recall that I did not have -- I did  
16 participate in the providing of this Notice Letter.  
17 This is the first time I've seen this letter to my --  
18 the best of my knowledge. I certainly did not draft it.

19 Q. Okay. All right. The next exhibit is posted.

20 A. E-mail-Meeting with Bryce.pdf?

21 Q. Yes.

22 A. Okay.

23 Q. Can you tell me what was discussed during this  
24 meeting between you and Bryce?

25 A. Yes. It was who was going to be on the



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1 committee.

2 Q. Okay. And what was that specifically?

3 A. We were trying -- we had a relatively short  
4 timeframe to put together the committee. And it was  
5 made difficult by a number of factors. Number one, July  
6 a frequent vacation time, you know, especially, in  
7 Mississippi where the kids go back to school right at  
8 the beginning of August. So that had to be factored in.  
9 Physicians have pretty tight schedules, you know,  
10 whether it's surgery or clinic or whatever there might  
11 be. So that was a challenge to make sure that we could  
12 accommodate people's schedules on short notice, which  
13 is, I can tell it's a nightmare to schedule -- to  
14 schedule meetings.

15 The other thing is, there's -- we needed a  
16 house staff member on the committee, another resident to  
17 get the resident's perspective of the process. The  
18 residents, I'm trying to think of what the right word  
19 is, they move to the next level on July 1st, so a fair  
20 number of the people who had been on the Graduate  
21 Medical Exchange Committee for residents would have  
22 graduated, so we not only had to find a resident, we had  
23 to find one that didn't graduate two weeks earlier. So  
24 all that took a lot of time and effort. And that's what  
25 Bryce and I were -- I was talking to Bryce about was

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1 getting that committee together.

2 Q. Was there a resident on the panel?

3 A. There was.

4 Q. Which panel member was that?

5 A. Hold on one second, I can tell you because  
6 I've got the letter pulled up over on my computer. It  
7 was Nilda Williams.

8 Q. Nilda Williams. Okay. Did you meet with  
9 anyone else regarding the appeal hearing other than  
10 Bryce?

11 A. I might have met with -- because I saw a  
12 comment in one of the e-mails you were showing me  
13 earlier. It talks about a Shirley. Shirley is Shirley  
14 Schlessinger who was, at that time, Rick Barr and  
15 Shirley were doing a handoff of that job. So Shirley  
16 was the former -- I think the position is actually --  
17 it's Dean of Graduate Medical Education or Associate  
18 Dean, and so Shirley was handing off and Rick was taking  
19 over. I might have talked to her, I don't remember. I  
20 don't remember a conversation about it.

21 But Bryce -- Bryce was -- was -- was really  
22 the important person in terms of getting the -- getting  
23 everything scheduled and getting the people there. And  
24 then I did have conversations -- certainly, had  
25 conversations with the hospital counsels.



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1           **Q.    And any meetings with Dr. Earl?**

2           A.    No.  Not that I recall.

3           **Q.    Any meetings with Dr. Barr?**

4           A.    I don't remember anything specific with Dr.  
5 Barr.  I met with Dr. Barr all the time on a variety of  
6 issues.  I can tell you we didn't talk about substance  
7 at all.  Because I base -- in terms of the specifics of  
8 the allegations because I really didn't dive into that  
9 until the hearing itself.

10          **Q.    What would you talk about that was not**  
11 **substantive?**

12          A.    We may have talked about the procedures.  I  
13 don't have a specific recollection of anything with him.

14          **Q.    In terms of what procedures needed to be**  
15 **followed for due process to be provided to Dr. Papin?**

16          A.    I doubt that -- I doubt that I spoke to that  
17 -- you used those words with Dr. Barr.  That's not whose  
18 advice I would have sought on that issue.  But we may  
19 have talked about, you know, who was going to be on the  
20 meeting; meaning, faculty members, not the individuals,  
21 but the type of people that was going to be on the  
22 committee.  But I'm just speculating now because I don't  
23 recall any specific conversation with Dr. Barr.

24          **Q.    In persons which you consulted with regarding**  
25 **the procedural or substantive due process issues, legal**

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1 counsel for UMMC, would that be Tommy Whitfield?

2 A. That will be Mark --

3 MR. WHITFIELD: I'm going to object going  
4 into the legal field.

5 MR. SCHMITZ: Yeah. I just want to know  
6 whether it was you or not that was advising him. I  
7 don't want to know the substance.

8 THE WITNESS: Is that okay, Tommy?

9 MR. WHITFIELD: I'm going to have him  
10 stand on my objection as to who was involved or who he  
11 -- he talked to legal, you know, we can leave it at  
12 that.

13 MR. SCHMITZ: He talked to Lee?

14 MR. WHITFIELD: Legal.

15 MR. SCHMITZ: Oh, legal. Can we go off  
16 the record for a second?

17 MR. WHITFIELD: Sure.

18 (Whereupon, an off the record.)

19 Q. (BY MR. SCHMITZ) All right. So when you  
20 consulted with legal regarding the substantive and/or  
21 potential procedural due process requirements for Dr.  
22 Papin's hearing with UMMC's legal team, who was present  
23 from UMMC's legal team at that meeting?

24 A. First of all, I would say, I didn't have any  
25 specific conversations about the breakdown of



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1 substantive versus procedural due process.

2 Q. Okay.

3 A. I didn't have that conversation with any --

4 MR. WHITFIELD: You can't answer that.

5 Q. (BY MR. SCHMITZ) I don't want to get into the  
6 substance now, you know.

7 A. So I had meetings regarding -- regarding the  
8 process of these hearings with Mr. Ray and Mr.  
9 Whitfield.

10 Q. Thank you. Next exhibit is up. This is your  
11 notebook, your notes that you had taken. And the first  
12 question -- take a look at it, and take your time, but  
13 the first question, are these your notes and your  
14 handwriting?

15 A. So I need you to ask that question formally.

16 Q. Are these your notes and is this your  
17 handwriting in this exhibit?

18 A. So for pages one through eight, they're are my  
19 notes and my handwriting.

20 Q. All right.

21 A. But pages nine and ten, that is my wife's  
22 handwriting. I dictated that letter to her when I was  
23 -- when we were driving on a long drive across country.

24 Q. Oh, nice, okay.

25 A. So that's her handwriting, which you can see a

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1 distinct change. But it was -- those are my words.

2 Q. Fair enough. Okay. When did you take these  
3 notes?

4 A. So I'm just scrolling up here. Sorry. So I'm  
5 going to go out of order. So page two, those are the  
6 notes, like page two, that's starting my notes I took  
7 during the hearing itself.

8 Q. Okay.

9 A. So page two, page three, page four, page five,  
10 page six, page seven, and page eight, so those are all  
11 -- those pages two through eight are my notes that I  
12 took during the hearing itself.

13 Q. Okay. In terms of page one?

14 A. Page one are the notes that I took during my  
15 conversation with Mr. Whitfield and Mr. Ray.

16 MR. WHITFIELD: Okay. Based on that, I'm  
17 going to make an objection to that being privileged  
18 notes an inadvertent disclosure under the case  
19 management order.

20 MR. SCHMITZ: Fair enough. Okay.

21 THE WITNESS: I do not know the date of  
22 that document.

23 MR. SCHMITZ: So you're instructing him  
24 not to answer any questions regarding page one --

25 MR. WHITFIELD: Correct. And I'd ask



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1 that be redacted and returned.

2 Q. (BY MR. SCHMITZ) I'm trying to think about  
3 this for a second. Are you aware of what UMMC's  
4 policies and procedures are regarding residency  
5 remediation plans?

6 A. Not anything specific, no.

7 Q. Okay. Do you have any sense or idea when  
8 remediation plans are supposed to be given to residents  
9 or when they're not offered to residents, I mean what  
10 are the distinguishing factors of what it is or is not  
11 offered?

12 A. No.

13 Q. Is it your experience that residents typically  
14 are residents that are having issues, whether that be  
15 academically or conduct related, are giving warnings and  
16 put on those types of remediation plans and given a  
17 chance to not continue doing whatever conduct warranted  
18 them getting on the remediation plan in the first place?

19 A. I think that depends. Certainly, academic  
20 deficiencies, there is -- there would be opportunities  
21 to remediate. Conduct, that's such a broad category, I  
22 don't think I can make a comment about that because  
23 there are obvious situations where someone would not  
24 have an opportunity to remediate based on their conduct.

25 Q. And you believe that Dr. Papin should not have

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1 had the opportunity to remediate based on his conduct in  
2 your general experience in the industry?

3 A. I believe that he did have an opportunity to  
4 remediate --

5 MR. WHITFIELD: Object to the form.

6 Q. (BY MR. SCHMITZ) Sorry. You can continue your  
7 answer, I don't know if you're done.

8 A. I said I do believe that Dr. Papin had plenty  
9 of opportunities to remediate his conduct.

10 Q. In terms of being given a formal actual  
11 remediation plan that's, you know, a performance  
12 improvement plan where everything was signed out, where  
13 he's giving a set timeline to improve, do you think that  
14 Dr. Papin should not have gotten that based upon his  
15 conduct?

16 A. I believe he got plenty of notice an  
17 opportunity to remediate and that he was -- that  
18 specific instances of his behavior, his conduct, his  
19 poor communication were discussed with him, and they got  
20 -- the situation got worse, not better.

21 So I don't -- I think that he got notice an  
22 opportunity to remediate. And he was --

23 Q. Well that's wasn't --

24 A. -- oh, go ahead.

25 Q. The question I asked was: Based upon your



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1 knowledge and experience, in this case, he was giving a  
2 formal remediation plan on January 10th and him and Dr.  
3 Earl both signed, that later he never actually got a  
4 chance to go through that plan with him because he was  
5 placed on administrative leave after that and never  
6 returned.

7 But do you believe that in these  
8 circumstances, I mean, obviously, there was a belief at  
9 least within UMMC that he should have -- because it was  
10 presented to him and he signed it, a chance to remediate  
11 his conduct?

12 A. Based on the information that I learned at the  
13 hearing, I do not believe that he should have been given  
14 formal -- an opportunity after that to remediate, no.

15 Q. Do you know why he was offered the remediation  
16 plan on January 10th, and then that -- what was the  
17 reason for the change in UMMC's position that on January  
18 10th that he should get one and then shortly thereafter,  
19 that he was not going to have that chance to do the  
20 things that they agreed to do with him in that document?

21 A. It is my understanding, that Dr. Earl believed  
22 that he was required to do this before terminating Dr.  
23 Papin. And that -- that is my understanding.

24 Q. Why would Dr. Earl as the Program Director for  
25 the General Surgery Program believe that he had that

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1 requirement?

2 A. I have no idea, you'd have to ask Dr. Earl.

3 Q. Are there any type of ACGME guidelines or  
4 requirements regarding remediation plans for residents?

5 A. I believe they're mentioned. I don't know the  
6 specific requirements. No. I don't believe there are  
7 -- I don't believe there are.

8 Q. In your role as the Chairperson over Dr.  
9 Papin's appeal, what was your understanding of the scope  
10 of your review of Dr. Papin's termination?

11 A. Whether -- I -- let me rewind that, I'm sorry.  
12 The first question is whether -- the first question we  
13 look -- that was important to us was whether he had  
14 notice an opportunity to improve to remediate. And then  
15 also whether the -- whether they're based on the  
16 information that we were provided, whether there was  
17 enough there to support his -- his termination.

18 Q. In your evaluation of the evidence that was  
19 provided to you, did you make any determinations  
20 regarding certain evidence that was provided to you not  
21 meeting a sufficient level of being substantiated or  
22 worthy of consideration that you -- that you may have  
23 dismissed in your decision to uphold Dr. Papin's  
24 termination?

25 A. I don't think we speci -- you know, with the



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1 exception of the -- the inappropriateness with the  
2 female student, I wouldn't say we -- we -- we dismissed  
3 anything. I think that we weighed it.

4 STENOGRAPHIC REPORTER: I'm sorry. It's  
5 froze.

6 THE WITNESS: Pardon?

7 STENOGRAPHIC REPORTER: I didn't get all  
8 of that, it's freezing up.

9 MR. SCHMITZ: Oh, okay. Is it better  
10 now?

11 STENOGRAPHIC REPORTER: I can hear you  
12 now.

13 THE WITNESS: Can you hear me?

14 STENOGRAPHIC REPORTER: I can hear you  
15 now, sir.

16 THE WITNESS: What was the last thing you  
17 heard me say?

18 STENOGRAPHIC REPORTER: "I wouldn't say  
19 we dismissed anything. I think we weighed it." And  
20 that was it.

21 THE WITNESS: Yeah. I wouldn't say that  
22 we dismissed anything except for that inappropriateness  
23 allegation, which we completely disregarded from our  
24 calculus. What we did, was we weighed the evidence and  
25 we weighed Dr. Papin's rebuttal.

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1 Q. (BY MR. SCHMITZ) Well let me change it then,  
2 not dismiss it, but were there anything that due to a  
3 lack of supporting evidence, was there any other facts  
4 which you weighed much lower than other, you know, I'm  
5 trying to get a sense of what you weigh as most  
6 important specifically and what you guys weighed at  
7 least important in your decision to uphold this  
8 termination?

9 A. I think that's really hard to say. Because we  
10 didn't really -- it wasn't like we were sitting around  
11 the table and ranking things. We discussed --

12 Q. In your mind -- in your mind? I mean in your  
13 mind what is -- what is -- what was the -- of the facts  
14 that we went over and the Notice thing before, what is  
15 the most important things that really cemented in your  
16 mind as upholding his termination, and what were the  
17 least important things?

18 A. Certainly, the most important things were the  
19 lack of professionalism and poor communication and  
20 inability to get along with team members. That was very  
21 high on there.

22 Q. It's pretty broad in terms of professionalism  
23 getting along with people. Was there a specific  
24 incident or interaction that he had with somebody?

25 A. You know, there were a lot of incidents and



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1 weighing them all together was how we came up with the  
2 decision. You know, we talked about a lot of different  
3 things. We reviewed the testimony. I can't really  
4 point to any one thing that was the most important or  
5 any one thing that was the least important because  
6 that's not the way the discussion went.

7 Q. Did you consider any alternative options to  
8 offer Dr. Papin in lieu of termination such as  
9 resignation or --

10 A. That was not my role. I was asked to conduct  
11 a hearing to determine whether or not his termination  
12 was justified, and that's what we did. We reviewed the  
13 --

14 Q. Do you know -- do you know whether you would  
15 have had the ability to make that decision or make that  
16 offer, if at the conclusion that you offer an  
17 alternative path, potentially, some alternative path,  
18 whether that be, you know, increase surveillance of Dr.  
19 Papin's work activities or resignation or any other  
20 alternative to termination?

21 A. That -- that was not an issue that we  
22 discussed in the deliberations. I know that  
23 specifically the question was raised by one of the  
24 faculty members during the hearing itself about whether  
25 Dr. Papin was offered the opportunity to resign. If I

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1 recall, I basically said that that's not what we're here  
2 for today when he asked that question.

3 I was asked to do a specific task, and that's  
4 what I did, and that's what we did.

5 Q. The hearing transcript is up as an exhibit.  
6 Without having to obviously look at the all 117 pages of  
7 this thing, I just kind of want to direct your attention  
8 to a couple of pages.

9 A. Bear with me. It's going to take a few  
10 minutes to load. I probably got three kids watching  
11 videos right now.

12 Q. I only have two, but I'll have three on  
13 Saturday.

14 A. Well congratulations.

15 Q. Thank you. Thank you. First boy coming, I  
16 have two girls now, so.

17 A. Okay. I can see it now.

18 Q. Okay. Well let me ask -- before we go to  
19 this. So you were sort of directing traffic during the  
20 hearing as the Chairperson for the hearing. Did you  
21 create an outline of anything you wanted to ask Dr.  
22 Papin or anything like that prior to the hearing?

23 A. Nothing prior to the hearing because, frankly,  
24 I knew very little about this case walking into the  
25 hearing. I was in thinking about this, I don't even



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1 think I had the documents in advance. I believe they  
2 were sent out to other faculty, the other members of the  
3 committee. But I think I believe I was actually left  
4 off that e-mail in reviewing some -- in reviewing the  
5 e-mails. So I don't -- I don't think I knew hardly  
6 anything about this until I walked into the room.

7 Q. So you hadn't reviewed any of the documents or  
8 the evidence presented to --

9 A. I do not believe that I --

10 Q. -- which supported Dr. Papin's, the  
11 allegations being brought against Dr. Papin except until  
12 you walked into the room for the hearing?

13 A. I believe that is correct.

14 Q. Do you think that that complies with  
15 procedural and substantive due process to provide Dr.  
16 Papin with a fair hearing to have the Chairperson of the  
17 hearing not to have reviewed any of the documents prior  
18 to the hearing?

19 A. I think it absolutely does. That's like  
20 judges hear cases all the time without hear -- seeing  
21 the documents in advance. I don't think the standard is  
22 that the individuals that are hearing the case, should  
23 review the evidence, some of which is very one sided  
24 because it comes from one side or the other in advance  
25 of the hearing. I think that actually would -- I don't

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1 think that that's what that means.

2 Q. Without having prior review of the evidence to  
3 support Dr. Papin's termination, do you think that you  
4 were prepared to ask him the appropriate questions or  
5 have the appropriate follow-up necessary to substantiate  
6 the actual allegations or the basis for these  
7 allegations that were made without reviewing documents?

8 A. We were relying on the witness testimony. And  
9 Mr. Papin had his attorney present and had the  
10 opportunity to speak to his attorney before and during  
11 the hearing. And so he was able to put forth issues  
12 that he thought benefited his position.

13 Q. So I mean in an appeal hearing for a resident  
14 being terminated, right, it's a big deal because this is  
15 basically someone's career one way or the other on the  
16 line; correct?

17 A. Sure. Sure. Yes. Yes.

18 Q. And so you didn't think it necessary as the  
19 Chairperson for that hearing, to even take the 20, 30  
20 minutes out of your time to review the documents that  
21 were regarding the case that you were going to be  
22 providing an opinion on, thumbs up or thumbs down on  
23 whether this person gets to be a doctor essentially or  
24 not?

25 MR. WHITFIELD: Object to the form.



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1                   THE WITNESS: Like I said, we were able  
2   to review those documents in realtime. We were able to  
3   hear from the witness. The witnesses were able to  
4   provide, you know, the reference -- specifically,  
5   reference the documents. I don't know of any standard  
6   that says that the committee hearing of matter should  
7   review the evidence before it's presented. Certainly,  
8   in my one year as a law clerk, I never saw that happen  
9   in a U.S. District Court.

10           Q.    (BY MR. SCHMITZ) But briefs and motions would  
11   be submitted prior to submitting --

12           A.    But not the evidence.

13           Q.    -- a motion; correct?

14           A.    Briefs certainly would be and legal arguments.  
15   But the evidence -- the evidence was brought in by the  
16   parties during the hearing or the trial itself.

17           Q.    They attach those as exhibits though to the  
18   motions and briefs?

19           A.    Certainly, not always. I would say less, you  
20   know, certainly, not in the criminal cases we heard.

21           Q.    Well that's criminal; right. In civil cases,  
22   you know, would --

23           A.    But I -- I.

24           Q.    -- attach the actual, you know, represented  
25   the documents as Exhibit A, you know, to support their

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1 motion. To support motions. I mean I just did that in  
2 the hearing I was in a minute ago. That's the regular  
3 course; correct?

4 A. Parties have an opportunity to do it in the  
5 court of law to attach exhibits. Whether or not they're  
6 reviewed is another thing all together, in terms of --  
7 in terms of actual evidence that's presented in the  
8 trial. It depends upon the style of the fact finder.

9 Q. And you think it's fair and reasonable for you  
10 to be the Chairperson of this committee with all -- what  
11 is at stake on behalf of Dr. Papin and to not have  
12 reviewed anything before walking in there, any  
13 documents, any of the evidence to make any at least  
14 determinations on how to direct the traffic or ask  
15 questions, no preparations were necessary prior to this?  
16 That's your -- that's your --

17 MR. WHITFIELD: Object to the form.

18 THE WITNESS: Yeah. First of all, I  
19 resent the statement or the pointed question that there  
20 was no preparation, that is false. In terms of  
21 reviewing the evidence on my own outside of the hearing  
22 and outside of the ability of the parties to be able to  
23 inform my view of that as a finder of fact, I would say  
24 that that was the appropriate thing to do, and I would  
25 hope that if I were in a hearing, that I wouldn't be



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1 pre-judged by the person running the hearing.

2 Q. (BY MR. SCHMITZ) And back in January when you  
3 were first talking to Dr. Barr or Dr. Earl regarding  
4 this, when they were requesting the iCARE reports or  
5 patient complaints on Dr. Papin, they had not informed  
6 you of any of their reviews prior to this?

7 A. First of all, I don't recall any questions --  
8 any conversations with Dr. Barr in January at all. I  
9 was at -- I don't recall any specific conversations with  
10 Dr. Earl as is shown in the e-mails, there was a request  
11 to obtain information about Dr. -- or whether Dr. Papin  
12 was contained in any of our data bases, which based on  
13 the documents, I had Darlene Bryant do.

14 Q. So you just got that request out of the blue  
15 and you had no -- there was no, hey, Dr. -- or Dr. Earl  
16 didn't come to you and say, hey, we call you up and say,  
17 hey, we've got this resident that we're -- that we're,  
18 you know, he's in the disciplinary process, I need you  
19 to see if there's been any patient complaints or  
20 anything, with no discussions of that substance or  
21 related like --

22 A. I don't recall -- I don't recall the substance  
23 of the conversation at all as I've said multiple times.  
24 What I can tell you is, if I was told that this person  
25 was going to be terminated or suspended, I would have

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1 remembered that conversation. That's an extraordinary  
2 unusual event.

3 Q. Okay.

4 A. As opposed to the day, you know, multiple  
5 times a week when I was asked about, hey, there's a  
6 patient on 77 west, did you get an event report. And  
7 I'd say, well, you know, let me go find out. So those  
8 requests for me to gather -- to gather information on  
9 other's behalf were common.

10 Q. The tables have been turned?

11 A. Yes.

12 Q. And Dr. Papin was your hearing, your hearing  
13 chairperson and your termination hearing and you were  
14 the resident?

15 A. Yes.

16 Q. Would you want Dr. Papin not to review any  
17 documents that substantiated the allega -- that  
18 allegedly substantiated allegations being brought  
19 against you that --

20 A. I would --

21 MR. WHITFIELD: Object to the form.

22 THE WITNESS: I would not want him to  
23 review the documents. I would like him to go into the  
24 hearing with an open mind, listen to what both sides  
25 have to say, and inform his impression on those



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1 documents based on that conver -- based on what was in  
2 the hearing room on the record as opposed to what  
3 happened outside.

4 Q. (BY MR. SCHMITZ) Okay. All right. Going to  
5 -- I'm going to be talking about the pages of the  
6 transcript itself, not the pdf's.

7 A. Got it.

8 Q. Page eight of the transcript.

9 A. Yes.

10 Q. Okay. If you look at the beginning of the top  
11 of the page at that. You're wading through I guess the  
12 ground rules for the -- what the hearing is going to be  
13 like. You're talking that Dr. Papin -- well I guess on  
14 the top of page seven, you're saying Dr. Papin will have  
15 the opportunity to address the committee, but not Dr.  
16 Earl specifically. And then followed up by any  
17 witnesses Dr. Earl thinks is appropriate.

18 Was Dr. Earl allowed to address Dr. Papin  
19 specifically and ask him questions?

20 A. No.

21 Q. And then Dr. Papin, it says will also have the  
22 opportunity to specifically address issues that are  
23 brought up at the time to the committee. And I guess  
24 you're talking about I guess at the very end of the  
25 presentation that each party will have an opportunity to

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1 address the committee. On line 19, you said:

2 "Furthermore, this is not a lawyer process." Correct?

3 A. Yes.

4 Q. But you're a lawyer; correct?

5 A. Yes. Well I'm an attorney by training. I'm  
6 licensed in the State of Connecticut in the Commonwealth  
7 of Massachusetts, and I maintain those professional  
8 licensure, but I'm not a practicing attorney. I don't  
9 -- I didn't represent the institution as an attorney.

10 Q. But you're a licensed attorney?

11 A. Yes. But not in the Miss -- not in the State  
12 of Mississippi. Employed as an attorney.

13 Q. So while this wasn't a lawyerly process, you  
14 were the only lawyer that was allowed to ask questions;  
15 correct?

16 A. Yes.

17 Q. And at the time of this hearing, you were an  
18 UMMC employee to ask -- doing what they asked you to do?

19 A. Yes.

20 Q. And you said that Joe -- Dr. Papin was not  
21 allowed to cross-examine witnesses; correct?

22 A. No one -- neither side was allowed to  
23 cross-examine witness -- was allowed to cross-examine  
24 witnesses.

25 Q. But you cross-examined witnesses; right?



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1           A.    I wouldn't necessarily call it  
2    "cross-examination" because that implies an adversarial  
3    nature of what we were doing.

4           Q.    Right. You were asked -- you were able to  
5    directly ask witnesses questions; correct?

6           A.    Yes. As were all the members of the  
7    committee. And, frankly, they asked more questions than  
8    I did.

9           Q.    And so you're a lawyer and also an employee of  
10   UMMC, and you're the only one that's allowed to ask --  
11   answer questions; correct?

12          A.    No --

13                   MR. WHITFIELD: Object to the form.

14                   THE WITNESS: -- every member of the  
15   committee were allowed to ask questions.

16          Q.    (BY MR. SCHMITZ) But you were the only lawyer  
17   in the room asking any questions; correct?

18          A.    Correct.

19          Q.    I'm going to go to page 10 of the transcript.  
20   And it's lines 21 and 22.

21          A.    Yes.

22          Q.    You reference the solemn decision that you  
23   have to make?

24          A.    Yes.

25          Q.    At that point, the solemn decision, you had

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1 already made your decision, at that point?

2 A. I'm sorry?

3 Q. You had already made your decision to uphold  
4 the termination of Dr. Papin?

5 A. No. Of course, not.

6 Q. Well what else would be a solemn decision that  
7 you have to make?

8 A. We have to make it, that's future tense.

9 Q. Ten pages into the hearing, you're already  
10 talking about the solemn decision that you had to make?  
11 What was --

12 A. Of course, this was -- this was a serious  
13 procedure. Your client's career was in the balance. We  
14 took that very seriously.

15 Q. But doesn't you as the Chairperson of that,  
16 using the word "solemn decision," doesn't that foretell  
17 which way the decision is supposed to go?

18 A. Of course, not.

19 Q. You don't think that that had any bias  
20 whatsoever on the rest of the panel when you were --

21 A. No. I think it was -- was -- I think it was  
22 reminding everyone in the room that this was a big deal.  
23 It was giving respect to Dr. Papin in the process that  
24 was being undertaken.

25 Q. But not -- you didn't have enough respect of



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1 the process that was being undertaken to review the  
2 documents before this -- before this hearing --

3 MR. WHITFIELD: Object. Asked and  
4 answered. Move on, man. We've been here four hours.

5 THE WITNESS: Yeah. All I can say, I  
6 don't know why you would want me to pre-judge the case.  
7 Because on one hand, you're asking me to pre-judge the  
8 case, and then you're saying -- you're saying that I  
9 didn't pre-judge it. And then you're upset.

10 Q. (BY MR. SCHMITZ) I'm asking you if you did?

11 A. Of course, not.

12 Q. Okay. Isn't it true, that the first time Dr.  
13 Earl ever mentioned to Dr. Papin that he was lying or  
14 being untruthful about the events in writing, is in the  
15 document that they both signed on January 10th, 2017,  
16 which was the remediation plan that he thought he was  
17 required to do?

18 A. I'm sorry, I don't understand that question.  
19 Can you say it again, please.

20 Q. When was the first time that Dr. Papin ever  
21 documented -- or not Dr. Papin -- Dr. Earl ever  
22 documented in writing to Dr. Papin that there were  
23 issues regarding his truthfulness?

24 A. To the best of my recollection, based on the  
25 information that I received, as a -- it was would either

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1 be in the November summative feedback document or in the  
2 -- in the postrotation feedback, but I'd have to look  
3 back to be sure.

4 Q. In the earlier meeting that we discussed  
5 earlier, the December 20th meeting, there's no mention  
6 made of lying in Dr. Earl's memorializing e-mail, is  
7 there?

8 A. I'd have to look at the e-mail. I'm not sure,  
9 was I a recipient of that e-mail?

10 Q. Okay. I sent another exhibit to the chat for  
11 review.

12 A. I can see it.

13 Q. At the bottom of the e-mail from Dr. Earl to  
14 his assistant Renee Greene, do you see that dated  
15 December 20th?

16 A. All I see is -- wait. Sorry. Yes. Yes, I  
17 see it. Uh-huh.

18 Q. Do you see Dr. Earl documenting or  
19 memorializing any instances of Dr. Papin lying in this  
20 December 20th e-mail regarding his discussion that he  
21 had with him on that same day?

22 A. I'll have to read it.

23 Q. Go ahead.

24 A. Okay. Can you ask your question again now  
25 that I've read it, please.



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1 Q. Do you see any instances where Dr. Earl is  
2 pointing out the fact that Dr. Papin was being  
3 untruthful and lying about anything in the meeting that  
4 he had with him on December 20th as stated in this  
5 e-mail?

6 A. Based on this e-mail, I do not see any of  
7 that. No.

8 Q. There were issues regarding the decubitus  
9 ulcer, they were brought up shortly after this e-mail;  
10 correct?

11 A. Those were either in late December or early  
12 January, but I do believe they were after this e-mail.  
13 Yes.

14 Q. Okay. Dr. Papin only works after this e-mail  
15 at the UMMC actually, physically working seeing patients  
16 up until January 10th, 2017; correct?

17 A. I don't remember the exact date that he left,  
18 but that sounds about right.

19 Q. So somewhere between this one, this e-mail and  
20 December 20th and January 10, there was some instances  
21 of untruthfulness that were brought to the attention of  
22 Dr. Earl, which were then transmitted to you through the  
23 appeal hearing?

24 A. Yes.

25 Q. And that incident would have been Dr.

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1 Mahoney's accusation that Dr. Papin did not tell her  
2 about the decubitus wound on the patient?

3 A. I believe that was one of them. Or I should  
4 say, yes, that was one of the items.

5 Q. Are you aware that Dr. Mahoney testified that  
6 she never looked at Mr. [REDACTED]'s chart?

7 A. I am not aware of that. I -- are you talking  
8 about in the hearing?

9 Q. No. At the -- during her deposition?

10 A. Oh, I have no knowledge of anyone's dep --  
11 specifics of anyone's deposition at all. I -- I --  
12 didn't even know she was deposed.

13 Q. And earlier I kind of talked about this, so if  
14 that was a lie and she had looked at the decubitus ulcer  
15 patient's chart 73 times between December 7th and  
16 December 20th, would that been something that would have  
17 drawn some suspicions on your part as to what the  
18 voracity, at least, occurred allegations against Dr.  
19 Papin?

20 A. I mean certainly the voracity of all the  
21 witnesses was important.

22 Q. Can you answer why you did not review the  
23 decubitus ulcer's medical chart as part of the  
24 termination review for Dr. Papin?

25 MR. WHITFIELD: I'm going to object.



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1 He's asked and answered that probably three times  
2 already. But he can answer, if you can.

3 THE WITNESS: Because we had witness'  
4 testimony to it. We had what Dr. Mahoney said. We had  
5 what Dr. Papin said. So we were able to get it from  
6 them.

7 Q. (BY MR. SCHMITZ) Are you aware of the  
8 complaint that the decubitus ulcer patient's family --  
9 are you aware of the complaint that the family made  
10 after Dr. Papin was gone that to UMMC, I think they  
11 reported to the office of Patient Affairs, that he was  
12 -- about a nurse leaving him in feces for approximately  
13 four hour time span after Dr. Papin was gone?

14 A. I don't know anything about that. No.

15 Q. If a complaint like that would have been made  
16 to the office of Patient Affairs, would they have picked  
17 up Mr. [REDACTED]'s patient chart and reviewed it to  
18 determine whether that happened or not?

19 A. They may or may not have. The individuals  
20 that staff the office of Patient Affairs, are not  
21 medical people. I frankly don't know what their -- I  
22 don't even know if they have access to the medical  
23 records. They're not nurses. They are patient affair  
24 specialists. When -- if that -- I'm speculating a  
25 little bit, but if that complaint had come into the

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1 office of Patient Affairs, I believe they would have  
2 contacted the nursing unit that the patient was cared  
3 for to get some details on it and then responded.

4 Q. Would the review of Mr. [REDACTED]'s family  
5 complaint about the incident I just described about him  
6 sitting in the feces for four hours, would that have  
7 come under sort of your hostages as your -- for  
8 investigation of follow-up as your role as the Risk  
9 Management Director at UMMC?

10 A. It is unlikely that that would have come to  
11 us. It would have fallen under a different category of  
12 my job because as I noted at the beginning of our  
13 conversation here today, that I was the Chairman of the  
14 Grievance Committee for the hospital. And -- but in  
15 terms of patient complaints and grievances; although,  
16 that's important, it needs to be appropriately  
17 addressed, if it's true, that's not the kind of thing  
18 that would -- the specifics would have -- that would  
19 have gotten to that committee.

20 Q. Sitting here today, you never personally,  
21 actually looked over that; correct?

22 A. Not to my knowledge. The -- the -- it would  
23 -- I didn't know the name of the patient with the  
24 decubitus ulcer until six or seven minutes ago. So,  
25 theoretically, could that have come across my desk, yes.



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1 But I --I -- I don't think so because that's something  
2 that -- that really wasn't within the scope of what I  
3 did every day.

4 Q. Was that brought to your attention as part of  
5 your role at the appeal hearing that there was a filed  
6 complaint about the same patient regarding the nursing  
7 care he was receiving?

8 A. Not that I recall.

9 Q. Who is Dr. Michael Henderson again?

10 A. Dr. Michael Henderson is the Chief Medical  
11 Officer for the University of Mississippi Medical  
12 Center.

13 Q. If the patient complaint came in, would he  
14 have reviewed the chart, the patient's family complaint,  
15 would he have had to review the chart?

16 A. It is unlikely. Possible, but unlikely.

17 Q. What is the Graduate Medical Education  
18 Committee?

19 A. To the best of my knowledge, the American  
20 College of Graduate Medical Education, requires every  
21 institution that has medical trainees; meaning,  
22 residents and fellows, to have a committee that over --  
23 over -- has oversight over all of the individual  
24 programs.

25 So at a big medical center like UMMC, you have

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1 a lot of different types of residents, you have surgery  
2 residents, you have internal medicine residents, you  
3 have pediatric residents, so there are many, many  
4 programs. 25 or 30 programs I'm sure; in addition, to  
5 those, you have subspecialty training. So Pediatric ICU  
6 like myself, those are separate programs. Each one of  
7 those programs is administered locally within that area  
8 training. So the Department of Pediatrics would have a  
9 program director for pediatrics. The division of  
10 pediatric critical care would have a program director  
11 for pediatric critical fellowship. All of those  
12 individuals are, in essence, supervised by the office of  
13 Graduate Medical Education.

14 The committee exist to review a lot of the  
15 things that surround -- surround those. And it's -- it  
16 could be many many things. It could be -- it could be  
17 the duty hours. It could be the adequacy of call room  
18 space. It could be funds for going to conferences. It  
19 could be, you know, if you didn't think your -- if you  
20 thought that your rotations were too heavily based on  
21 clinical service as opposed to truly receiving the  
22 teaching, they might review that. The committee is made  
23 up of a blend of faculty members as well as house staff,  
24 residents, and fellows.

25 Q. How many people are on the committee?



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1           A.    It's large. I don't know for sure. But it  
2   was in a -- I mean there were meetings that I was at  
3   where there were 20 -- more than 20 people there.

4           **Q.    At Dr. Papin's termination hearing, who**  
5   **decided which witnesses would be called?**

6           A.    I believe that it was Dr. Earl decided who --  
7   what witnesses will be called on behalf of the  
8   Department of Surgery's Residency Program.

9           **Q.    Did he notify you in advance which witnesses**  
10   **would be called?**

11          A.    I don't know if I was notified exactly. I did  
12   see that there was a witness list on that letter that  
13   you showed me earlier that went out to Dr. Papin. But I  
14   don't believe I saw that letter before today. I don't  
15   recall seeing it before. But I don't believe that the  
16   witness list was discussed with me. No.

17          **Q.    Do you know if anyone had notified Dr. Papin**  
18   **that he had the ability to also call witnesses, if he**  
19   **wanted to?**

20          A.    I don't know whether that happened in advance.  
21   I certainly discussed it with Mr. Dillard during the  
22   hearing.

23          **Q.    Whose responsibility was it to let Joe -- Dr.**  
24   **Papin to know about these types of things, like call**  
25   **witnesses, documents, evidence, and all that kind of**

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1     **stuff? If it wasn't you, then whose responsibility**  
2     **would it have been?**

3           A.     My assumption it would be the GME office.

4           **Q.     So Dr. Barr?**

5           A.     Well I -- Dr. Barr at that -- like I said, Dr.  
6     Barr and Dr. Schlessinger were having that handoff. I  
7     don't know when that formally occurred. But,  
8     ultimately, one of them or both.

9                     MR. WHITFIELD: I'm going to object to  
10    that last question. He wasn't a 30(B)(6) witness for  
11    the institution on that topic. He can answer as best of  
12    his knowledge.

13           **Q.     (BY MR. SCHMITZ) When did you and the**  
14    **committee afterwards meet to make a decision on Dr.**  
15    **Papin's termination?**

16           A.     We met immediately after the hearing.

17           **Q.     Everybody was in person, this was a full in**  
18    **person meeting?**

19           A.     Correct.

20           **Q.     How long did you guys take to discuss the**  
21    **matter?**

22           A.     It was over an hour or close to it. I don't  
23    -- I wouldn't remember. It was not brief because it was  
24    late in the day.

25           **Q.     Is any portion of that meeting or notes**



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1 regarding the actual decision part of the meeting  
2 between the panel, was any of that taken down in  
3 writing?

4 A. No.

5 Q. Was anyone in attendance at the meeting other  
6 than the hearing panel?

7 A. No. Not to my recollection. I know that Dr.  
8 Barr and Dr. Earl were not there. But I think everybody  
9 left. I think the lawyers -- certainly, the lawyers all  
10 left.

11 Q. Do you agree when a resident is terminated in  
12 circumstances such as Dr. Papin as a danger to patients'  
13 safety, is likely never going to be accepted into  
14 another reputable residency program thereafter?

15 MR. WHITFIELD: Object to the form.

16 THE WITNESS: I think that it would be  
17 extraordinarily challenging to get another job. I think  
18 there are circumstances by which one could rehabilitate  
19 oneself, and if one had a compelling story about  
20 self-discovery, I think they -- they -- they would have  
21 a chance. But I -- it would be extraordinarily  
22 difficult. Yes.

23 Q. (BY MR. SCHMITZ) All right.

24 MR. SCHMITZ: I'm going to take two  
25 minutes. I think I'm about done here. And then I'll be

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1 right back. Okay?

2 MR. WHITFIELD: Go ahead.

3 MR. SCHMITZ: I'm just going to make  
4 sure.

5 (Whereupon, a recess was taken at this time.)

6 MR. SCHMITZ: One more question.

7 Q. (BY MR. SCHMITZ) Do you believe that there was  
8 any conflict between your role for managing risk for  
9 UMMC and your ability to give Dr. Papin a fair hearing?

10 A. No.

11 Q. Why?

12 A. I believe that -- let me think about that a  
13 little bit differently. I think that doing right by our  
14 employees an our house staff, is everything that -- it  
15 is what quality safety risk management is about. So,  
16 you know -- you know, the house staff -- having house  
17 staff is a -- an any kind of trainees always presents  
18 risks for the institution.

19 But the education of these individuals is so  
20 important for the overall mission of the medicine, that  
21 -- that it's part of what we do. So I didn't really see  
22 it as a -- as that kind of role. I think that part of  
23 the problem is, that the perception of risk management  
24 is somebody who just wants to make troubles go away, and  
25 that's not really what it is in medicine. But risk



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1 management and medicine is about -- is about learning  
2 and a constant process of improvement in excellence and,  
3 you know, in quality and patient safety.

4 My role in risk management was -- was -- was  
5 focused there, but also certainly in terms of there's an  
6 educational mission as well.

7 Q. So the fact that there were issues brought up  
8 regarding patient safety with Dr. Papin and potentially  
9 you being able to eliminate that risk by upholding his  
10 termination, did not factor into your decision at the  
11 appeal hearing?

12 A. Never entered into my mind a bit.

13 Q. All right.

14 MR. SCHMITZ: I have nothing further.

15 MR. WHITFIELD: Nothing further.

16 (Whereupon, deposition concluded at 5:30 p.m.)

17 SIGNATURE/NOT WAIVED

18

19 ORIGINAL: MR. GREGORY SCHMITZ, ESQ.

20 COPY: MR. TOMMY WHITFIELD, ESQ.

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1 CERTIFICATE OF THE DEPONENT

2 DEPONENT: Steven Bondi, M.D.  
3 DATE: February 3rd, 2021  
4 CASE STYLE: Joseph Papin vs. University of  
Mississippi Medical Center; Dr. Louann Woodward, Dr. T.  
Mark Earl

5  
6 I, the above-named deponent in the deposition  
7 taken in the herein styled and numbered cause, certify  
8 that I have examined the deposition taken on the date  
above as to the correctness thereof, and that after  
reading said pages, I find them to contain a full and  
true transcript of the testimony as given by me.

9 Subject to those corrections listed below, if  
any, I find the transcript to be the correct testimony I  
gave at the aforestated time and place.

| 10 | Page  | Line  | Comments |
|----|-------|-------|----------|
| 11 | _____ | _____ | _____    |
| 12 | _____ | _____ | _____    |
| 13 | _____ | _____ | _____    |
| 14 | _____ | _____ | _____    |
| 15 | _____ | _____ | _____    |
| 16 | _____ | _____ | _____    |
| 17 | _____ | _____ | _____    |

18 This the \_\_\_\_ day of \_\_\_\_\_, 2021.

19  
20 \_\_\_\_\_ STEVEN BONDI, M.D.  
21 State of Mississippi  
County of \_\_\_\_\_

22 Subscribed and sworn to before me, this the \_\_\_\_  
23 day of \_\_\_\_\_, 2021.

24 My Commission Expires:

25 \_\_\_\_\_  
Notary Public



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C E R T I F I C A T E

STATE OF MISSISSIPPI

COUNTY OF HINDS

I, MELLIE PIERCE, hereby certify that the above and foregoing deposition was taken down by me on Computerized Stenotype, and the questions and answers thereto were transcribed by me, and that the foregoing represents a true and correct transcript of the deposition given by said witness upon said hearing.

I further certify that I am neither of counsel nor of kin to the parties in the action, nor am I in any way interested in the result of said cause.

Witness my signature this the 14th day of February, 2021.

*Mellie M. Pierce*

MELLIE M. PIERCE, CCR #1933

My Commission Expires: 10/27/23

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